FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11201	**Perform EDI Oversight**	The costs related to the establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, remittance advice, eligibility query, claims status query, and other purposes; and/or between Medicare and a bank for electronic funds transfer or remittance advice. **Reference:** • Internet Only Manual – Medicare Claims Processing Manual Chapters 22, 24, 25, 26 and 31 • CRs amending the IOM CR 2819-Ch. 24/Section 40.7 CR 2879– Ch. 24/Section 40.1 CR 2966-Ch. 24/Section 90 CR 3001 – Ch/ 31/Section 20.7 CR 3017 – Ch. 31/Section 20.7 CR 3050 – Ch. 24/Section 40.7.2 CR 3100 – Ch. 24/Section 70 • Joint Signature Memo (RO-2323, 10-19-03)	a. Obtain valid EDI and EFT agreements, provider authorizations for third party representation for EDI, and network service agreements. Enter that data into the appropriate provider-specific and security files, and process reported changes involving those agreements and authorizations b. Issue/control/update/monitor passwords and EDI billing/inquiry account numbers c. Sponsor providers and vendors to establish IVANS, other private network, and LU 6.2 connections d. Systems test with electronic providers/agents to assure compatibility for the successful exchange of data e. Submit EDI data, HIPAA implementation status, and submitter HIPAA testing status reports f. Monitor and analyze recurring EDI submission and receipt errors, and coordinate with the submitters and receivers when necessary to eliminate errors g. Investigate high provider eligibility query to claim ratios and initiate corrective action as needed h. Maintain a list on your web page of software vendors whose EDI software has successfully tested for submission of transactions to Medicare i. Provide support to providers on the use of the free/low cost billing software j. Provide basic support to providers on interpretation of transactions issued by Medicare	

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11202	**Manage Paper Bills/Claims**	All costs related to the receipt, control, and entry of paper bills and for maintenance of the standard paper remittance advice format. This activity encompasses tasks prior to and following the shared system process. **Reference:** • Medicare Claims Processing Manual, Chap 1, Section 40.4.1, 50, 50.1.1, 50.1.8, 50.2, 80, 80.1, 80.2.1, 130, 130.1., Chap. 22, Sections 10, 20,30, 50, 50.2, Chap. 24, Sections 40.3.2, 40.4, Chap. 25, Section 50.1	a. Receive, open, sort and distribute incoming bills/claims, including paper adjustment bills b. Assign control numbers and date of receipt c. Image paper claims and attachments, including adjustment bills d. Perform data entry (whether manual or electronic scanning) e. Identify claims that cannot be processed due to incomplete information (field or scrubber edits) f. Resolve field edit errors g. Return incomplete paper claims or paper claims that failed field edits to providers for correction and resubmission h. Re-enter corrected/developed paper claims adjustment actions. Manage paper bills, including paper adjustment bills i. Update the standard paper remittance advice format annually, if directed by CMS	**Workload 1** is the difference between the total bills reported on the HCFA-1566, Page 11, Line 38, Column 1 minus the EMC bills reported in Line 38, Column 8.

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11203	**Manage EDI Bills/Claims**	Establish, maintain and operate the infrastructure for EDI and DDE for claims, remittance advice, status query, eligibility query and EFT. Requires 1 upgrade per year in each of the EDI formats supported, free billing software, PC-Print software, and related tasks. **Reference:** • Internet Only Manual – Medicare Claims Processing Manual Chapters 22, 24, 25, 26 and 31 • Activity related CRs: CR 2840/Ch. 24 CR 2900/837P CD Modification CR 2947/835 CD/FF Modification CR 2948/835 CD Modification CR 2964/Ch. 24 CR 3065/Ch. 31 CR 3095/Ch. 24/Section 40.73 Ch. 3101/Ch. 24/Section 70.1 & 70.2 • CDs and FFs for 837I, 835P, 835 and 276/277	a. Provide free billing software, PC-Print software, and upgrade once per year b. Alpha test and validate free billing and PC-Print software c. Assist with resolution of problems with telecomm protocols and lines, your software and hardware, and with the processing of magnetic tapes if supported to maintain connectivity with partners d. Maintain capability for receipt and issuance of transactions via DDE and in batches, for DDE and batch correction of edits, and submission of adjustments via DDE and batch e. Maintain EDI access, syntax and semantic edits at the front-end, prior to shared system processing f. Route edit and exception messages, claim acknowledgements, claim development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners; route EFTs g. Maintain back-end edits to assure remittance advices 835 and 277 query responses comply with the implementation guide requirements, and EFTs comply with the ACH or 835 requirements h. Create copy of EDI claims including adjustment claims as received from submitters and have the ability to recreate each outgoing remittance advice and COB transactions i. Maintain audit trails to document processing of EDI transactions j. Translate transaction data between pre HIPAA and the HIPAA standard formats and the corresponding shared system flat files	**Workload 1** is reported on the HCFA-1566, Page 11, Line 38, Column 8.

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
			k. Update claim status and category codes, revenue codes, claim adjustment reason codes, remittance advice remark codes l. Bill third parties for electronic access to beneficiary eligibility data, maintain receivables for those accounts, and terminate third parties for non-payment	

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11204	**Bills/Claims Determination**	Most of the costs related to the determination of whether or not to pay a claim after claim entry and initial field edits are automated and captured under the Run Systems activity. However, operational support staff is required to support claims pricing and payment in conjunction with the programming activities included under Run Systems. Costs of these support activities, which include the creation, maintenance, and oversight of reasonable charge screens, fee schedules, and other pricing determination mechanisms that support claims payment processing systems, are reported under the Claims Determination activity. Also, the cost of any staff intervention in the adjudication of claims resulting from automated claims payment edits should be assigned to this activity.	a. Maintain fee schedule (local variations) b. Check for duplicates c. Identify claims that have to be resolved manually d.Re-enter corrected/developed claims (pending) e. Resolve edits on claims that cannot be processed (if possible) f. Maintain pricing software modules g. Update HCPCS, diagnostic codes and other code sets that impact pricing as needed	**Workload 1** for adjudicated bills is the cumulative number of bills processed reported on the HCFA-1566, Page 1, Line 12, Column 1.

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11205	**Run Systems**	The costs of procurements and the programmer/management staff time associated with the systems support of claims processing outside those provided by the standard system maintainer under direct contract to CMS. It also includes, but is not limited to: CPU costs for claims processing (including those associated with the application of MIP edits); validating new software releases; maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; and ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs.	a. Test releases b. Assign Data Center costs c. Purchase software/hardware d. Generate data for MSNs/EOMBs/NOUs, paper remittance advices, and paper checks (Note: any associated printing and mailing costs will be included in the "Manage Outgoing Mail" activity) e. Manage change requests	
11206	**Manage Information Systems Security Program**	The costs necessary to adhere to the CMS information systems security policies, procedures and core security requirements, re: the CMS Business Partner Systems Security Manual (BPSSM). **Reference**: • BPSSM Section 2.2 • BPSSM Section 3.1 • BPSSM Section 3.2 • BPSSM Section 3.3 • BPSSM Section 3.4 • BPSSM Section 3.5.1 • BPSSM Section 3.5.2 • BPSSM Section 3.6 • BPSSM Section 3.7	a. Principal Systems Security Officer (PSSO) staffing (including support staff), and training and supporting PSSO functions and responsibilities (Section 2 of the BPSSM) b. Conduct an annual self-assessment using CAST (A-2 of the BPSSM) c. Develop, review and update the systems security plans (Section 3.1 of the BPSSM) d. Conduct, review and update the Information System Risk Assessment (Section 3.2 of the BPSSM) e. Prepare the annual systems security component of internal control certification (Section 3.3 of the BPSSM) f. Prepare, review, update and test the information technology systems contingency plan (Section 3.4 of the BPSSM) g. Conduct an Annual Compliance Audit and	

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		• BPSSM Section 3.8	implement Corrective Action Plans to resolve resultant findings (Section 3.5 of the BPSSM) h. Develop Computer Incident Reporting and Response Procedures (Section 3.6 of the BPSSM) i. Develop and maintain a system security profile (Section 3.7 of the BPSSM)	
11207	**Perform Coordination of Benefits Activities with the Coordination of Benefits Contractor (COBC), Supplemental Payers, and States**	The costs associated with the continuation of activities related to the crossing over of Medicare processed claims data to existing trading partners and costs associated with the transmission of Medicare processed claims to the COBC. **Reference:** • Pub. 100-04, Section 70.6, Chapter 28	a. Maintain and support your existing Trading Partner Agreements (TPAs) during transition to the COBA process, including providing assistance to the trading partner as it cancels its TPA and coordinates its COBA implementation to avoid loss of crossed claims. b. Coordinate with the COBC to ensure that 837 flat file transmission issues, including transmission problems, data quality problems, and other technical difficulties, are resolved timely. c. Upon issuance of a CMS program transmittal, coordinate with the COBC to ensure that trading partner requests for retrospective claims (COBA recovery process) are processed timely.	**Workload 1** is the number of claims transferred as designated in the Pub. 100-06 (IER and FACP reporting). **Workload 2** is the number of claims crossed to the COBC (IER and FACP reporting).
11208	**Conduct Quality Assurance**	The costs related to routine quality control techniques used to measure the competency and performance of claims processing personnel; quality assurance reviews of fee schedules, HCPCS and ICD-9 updates and maintenance; and review of contractor systems.	a. Review suspended/reopened claims for correct processing b. Review processed paper/EMC claims for accuracy c. Perform other QC sampling techniques for claims processing d. Perform QA on fee schedules maintenance and contractor systems	

FY 2005 Bills Payment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11209	**Manage Outgoing Mail**	The costs to manage the outgoing mail operations for the bills/claims processing function (e.g., costs for postage, printing NOUs/MSNs/EOMBs, remittance advices and checks, and paper stock). **Reference:** • Medicare Claims Processing Manual, Chap 1, Section 20 • Medicare Claims Processing Manual Chap. 22, Section 10	a. Mail NOUs/MSNs/ EOMBs, paper remittance advices, and checks b. Mail requests for information (other than medical records or MSP) to complete claims adjudication c. Return unprocessable claims to providers d. Return misdirected claims e. Forward misdirected mail	
11210	**Reopen Bills/Claims**	The costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error, inaccurate coding, input error, or the misapplication of reasonable charge profiles and screens, etc. *(Note: Include the cost of processing an adjustment, but only if the adjustment is specifically related to a reopening. Do not include the cost of an adjustment to a claim that results from an appeal decision).* **Reference:** Internet Only Manual-Publication 100-4, Chapter 29, Section 60.27	a. Receive written inquiry or referral for reopening b. Control and image claim c. Research validity of issues related to the reopening d. Adjust claim as appropriate e. Issue response related to claims determination if necessary (e.g., a revised NOU or EOMB) f. Refer to other areas if appropriate to the circumstances g. Document and maintain files for appropriate retrieval	

FY 2005 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
12090	**Part B Quality Improvement/ Data Analysis**	All costs and workload associated with appeal quality improvement and data analysis. **Reference:** • AB-03-139	a. Identify reasons for full or partial reversals and dismissals b. Identify denials due to medical review edits c. Identify providers/suppliers with high review rates and high reversals d. Identify problems/issues that have the highest rate of appeal or reversal e. Identify percentage of each level of appeal that result in full reversals, partial reversals, and affirmations f. Report on claims processing system errors, provider errors, and delayed documentation submission that result in denials and the potential affect on appeals review requests g. Forward the results of data analysis and any recommendations to appropriate components (e.g. Medical Review, Provider Education, etc.) h. Take corrective action as needed i. Perform Quality Control Checks as instructed in the PM j. Create and maintain an effective system for internal feedback loops k. Submit reports to CMS as specified in official instructions	
12110	**Part A Reconsiderations/ Redeterminations**	All costs and workloads associated with conducting the Reconsideration/Redetermination. **Reference:** • §1869 and §1816(f)(2)(A)(i) of the Act • 42 CFR §405.710-405.717 • Medicare Claims Processing Manual, Chap. 29, Section 40.2, 40.3, 40.4 • AB-03-133 • Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 • Sections 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act	a. Receive reconsideration/redetermination request in corporate mailroom and date stamp b. Assign contractor control number (CCN) to request c. Scan reconsideration/redetermination request and other documentation as necessary d. Forward request to appropriate department e. Begin reconsideration/redetermination case preparation, validate request f. Enter data as necessary into system/database g. Write and mail a reconsideration/redetermination dismissal letter, if necessary, or h. Write and mail a reconsideration/redetermination acknowledgement letter i. Obtain consultant/RN/specialist opinion as necessary j. Write or call appellant to request additional documentation as necessary k. Make a determination about the reconsideration/redetermination request l. Write and mail a reconsideration/redetermination determination letter to appellant and cc: other parties	**Workload 1** Reconsideration/ Redetermination Requests Cleared (claims) (CMS-2591, Line 7, Column 1) **Workload 2** Reconsideration/ Redetermination Requests Cleared (cases) (CMS-2591, Line 6, Column 1) **Workload 3** Reconsideration/ Redetermination Requests Reversed (cases) (CMS-2591, Line 11, Column 1)

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CAFM Code	Activity Name	Definition	Tasks	Workload
		of 2003 • CR 2620	m. Request and receive written assurance from provider that payment has not been made prior to the decision n. If decision is partially or wholly reversed, effectuate decision (make payment) and close case o. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request	
12113	**Incomplete Reconsideration/ Redetermination Requests**	All costs and workloads associated with returning incomplete or unclear requests for Reconsideration/Redetermination. **Reference:** • Medicare Claims Processing Manual, Chap. 29, Section 40.2.1C **Reference:** • Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000; • Sections 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act 2003 • CR 2620	a. Receive unclear or incomplete request from provider or state b. Return it with clarification of what is required for a reconsideration/redetermination request c. Maintain a count of returned reconsideration/redetermination requests and enter this count into CAFMII	**Workload 2** Incomplete Reconsideration/ Redetermination Requests (cases) (not currently captured on the CMS-2591)
12120	**Part A ALJ Hearing Requests and Effectuations, and DAB Referrals, Requests for Case Files, and Effectuations**	All costs and workloads associated with processing ALJ hearings, including receiving requests, preparing case files, and implementing ALJ decisions. All costs associated with processing DAB referrals, DAB requests and DAB effectuations. **Reference:** **Part A ALJ requests and effectuations**: • §1869 and §1816(f)(2)(A)(ii) of the Social Security Act • 42 CFR §405.720-405.722 • Medicare Claims Processing Manual, Chap. 29, Section 40.5,	**For Part A ALJ requests and effectuations:** a. Receive ALJ hearing request in corporate mailroom and date stamp it b. Assign a contractor control number to ALJ hearing request c. Scan ALJ hearing request and any other documentation, if applicable d. Forward ALJ hearing request to the appropriate department e. Enter data as necessary into system/database f. Prepare and send ALJ hearing request acknowledgement letter g. Assemble ALJ hearing case file and make and maintain an exact copy h. Forward ALJ hearing case file to OHA i. Receive and control ALJ hearing file and decision j. Review ALJ decision k. Request and receive written assurance from provider that	**Workload 1** ALJ Hearing Requests Forwarded (claims) (CMS-2591, Line 57, Column 1) **Workload 2** ALJ Hearing Requests Forwarded (cases) (CMS-2591, Line 56, Column 1) **Workload 3** ALJ Hearings Effectuated (cases) (CMS-2591, Line 72, Column 1)

FY 2005 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		40.6, 40.7, 50.7**AB-03-133** • **Part A DAB referrals, requests for case files, and effectuations:** • 42 CFR §405.724 • Medicare Claims Processing Manual, Chapter 29, Section 40.6, 40.7 **Misc. Code:** 12120/01 – **Courier Service Fees** – All costs of using a courier service to forward requests for Part A ALJ hearing and case files. AB-03-144	payment has not been made prior to ALJ decision (if whole or partial reversal) l. Compute the amount due to the appellant/party based on the ALJ decision (if whole or partial reversal) m. Enter data as necessary into system/database n. If no referral, effectuate ALJ decision o. Place documentation confirming payment has been made in case file, if applicable p. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals **For Part A DAB referrals, requests for case files, and effectuations:** a. Prepare draft Agency Referral memo and case file, and forward to lead RO or b. Receive and control the appellant's DAB review request or the DAB's request for a case file c. Retrieve case file d. Copy any additional correspondence and make a copy of the original case file and maintain e. Send original case file to the DAB f. Effectuate DAB's decision g. Enter case status information throughout the process of this activity and update as necessary	
12141	**Part B Telephone Reviews**	All costs and workloads associated with conducting telephone reviews/redeterminations. Telephone reviews/redeterminations are those reviews/redeterminations that are requested by telephone and subsequently completed over the telephone. **Misc. Code:** 12141/01 – **Dismissals/Withdrawals of Part B Telephone Reviews/Redeterminations** – All costs associated with processing telephone reviews/redeeterminations that	a. Take all pertinent information for review/redetermination request over the telephone b. Determine if the review/redetermination can be handled over the telephone c. Log Request into system and assign control number d. Enter data as necessary into system/database e. Conduct the review/redetermination over the telephone and evaluate evidence/case history f. Make a review/redetermination determination g. Write a review/redetermination determination letter (if wholly or partially unfavorable), if beneficiary initiated write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) h. Mail a review decision letter to parties	**Workload 1** Telephone Review Requests Cleared (claims) (not included in the CMS-2591) **Workload 2** Telephone Review Requests Cleared (cases) (not included in the CMS-2591) **Workload 3**

FY 2005 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		are dismissed or withdrawn.	i. If decisions partially or wholly reversed, effectuate decision j. Enter case status information throughout the process of this activity and update as necessary k. Maintain an accurate count of telephone reviews/redeterminations completed and reversed and enter this data into CAFMII	Telephone Review Reversals (not included in the CMS-2591) Telephone Review Requests Dismissed or Withdrawn (not included in the CMS-2591)
12142	**Part B Written Reviews**	All costs and workloads associated with completing a written review/redetermination. Written reviews/redeterminations are those reviews that are requested in writing and subsequently completed in writing. **Reference:** • §1869 and §1842(b)(2)(B)(i) of the Social Security Act • 42 CFR 405.807 – 405.812 • Medicare Claims Processing Manual, Chap. 29, Section 50.3 • AB-03-133 • Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000; • Sections 933 and 940 of the Medicare Prescription Drug, Improvement and Modernization Act 2003 • CR 2620 **Misc. Code:** 12142/01 – **Dismissals/Withdrawals of Written Reviews** – All costs associated with processing written	a. Receive written review/redetermination request in corporate mailroom and date stamp request b. Assign contractor control number (CCN) to review request c. Scan review/redetermination request and any other documentation, if applicable d. Forward review/redetermination request to appropriate department e. Begin case preparation and validate request f. Enter data as necessary into system/database g. Evaluate evidence and case history of review request h. Obtain consultant/RN/specialist opinion for review/redetermination request, if necessary i. Write or call appellant to request additional documentation for the review/redetermination, if necessary j. Receive, scan and control additional documentation for review/redetermination, if necessary k. Make a determination about the review/redetermination request l. Write a review/redetermination determination letter (if wholly or partially unfavorable), if beneficiary initiated, write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) m. Mail review/redetermination determination letter to parties, if applicable n. If decision is partially or wholly reversed, effectuate decision o. Enter case status information throughout the process of this activity and update as necessary, maintain/story case	**Workload 1** Written Requests Cleared (claims) (CMS-2591, Line 7, Column 5) **Workload 2** Written Requests Cleared (cases) (CMS-2591, Line 6, Column 5) **Workload 3** Written Requests Reversals (cases) (CMS-2591, Line 11, Column 5) Written Requests Dismissed or Withdrawn (cases) (CMS-2591 Line 10, Column 5)

FY 2005 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		reviews/redeterminations that are dismissed or withdrawn.	file for possible HO Hearing Request	
12143	**Part B Incomplete Review Requests**	All costs and workloads associated with handling incomplete or unclear requests for reviews/redeterminations. **Reference:** • Medicare Claims Processing Manual, Chap. 29, Section 50.3 .1B • CR 2620	a. Receive unclear or incomplete request from provider or state b. Return it with clarification of what is required for a review/redetermination request c. Maintain a count of all returned review/redetermination requests and enter this count into CAFMII	**Workload 2** Incomplete Review Requests Received (cases) (not currently captured on the CMS-2591)
12150	**Part B Hearing Officer Hearings**	All costs and workloads associated with processing, and conducting on-the-record, telephone, and in-person Hearing Officer (HO) Hearings. All costs and workloads associated with processing a dismissal/withdrawal of a Hearing request. **Reference:** • §1869 and §1842(b)(2)(B)(ii) of the Social Security Act • Medicare Claims Processing Manual, Chap. 29, Section 50.4, • AB-03-133	a. Receive HO hearing request in mailroom b. Assign contractor control number (CCN) to HO hearing request c. Scan HO hearing request and any other documentation, if applicable d. Forward HO hearing request to appropriate department e. Begin HO hearing case preparation and validate request f. Enter data as necessary into system/database g. Write and send a HO hearing acknowledgement letter h. Prepare the HO hearing case file i. Schedule the hearing j. Provide written notice of the hearing k. Pre-examine the HO hearing evidence l. Enter data as necessary into system/database m. Examine the applicable sections of the statues, regulations, rulings, policy statements, general instructions and formal guidelines to prepare for the HO hearing n. Travel o. Conduct the HO hearing p. Receive medical review for the HO hearing, if necessary q. Make a determination about HO hearing request r. Write and mail a HO hearing decision letter to appellant s. Effectuate the decision if whole or partial reversal t. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request	**Workload 1** HO Hearings Completed (claims) (CMS-2591, Line 7, Column 6) **Workload 2** HO Hearings Completed (cases) (CMS-2591, Line 6, Column 6) **Workload 3** HO Hearings Reversed (cases) (CMS-2591, Line 11, Column 6)

FY 2005 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
12160	**Part B ALJ Hearing Requests and Effectuations, and DAB Referrals, Requests for Case Files, and Effectuations**	All costs and workloads associated with the processing of ALJ hearing requests and effectuations. All costs associated with processing DAB referrals, DAB requests and DAB effectuations. **Reference:** • 42 CFR 405.855 and 42 CFR 405.856 • Medicare Claims Processing Manual, Chap. 29, Section 50.7 AB-03-133 • AB-03-144 **Misc. Code:** 12160/01 – **Courier Service Fee** – All costs of using a courier service to forward requests for Part B ALJ hearing and case files.	**For Part B ALJ requests and effectuations:** a. Receive written ALJ hearing request b. Assign CCN c. Scan requests, referrals, and any other documentation, if applicable d. Forward ALJ hearing request to appropriate department e. Enter data as necessary into system/database f. Prepare and send an acknowledgement letter g. Assemble case file and make and maintain an exact copy of the file h. Forward case file to OHA i. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals j. Receive and control case file and decision k. Compute the amount due to the appellant/party based on the decision (if whole or partial reversal) l. Enter data as necessary into system/database m. Effectuate decision if whole or partial reversal n. Place documentation confirming payment has been made in the case file, if applicable	**Workload 1** ALJ Hearing Requests Forwarded (claims) (CMS-2591, Line 57, Column 5) **Workload 2** ALJ Hearings Effectuated Forwarded (cases) (CMS-2591, Line 56, Column 5) **Workload 3** ALJ Hearings Effectuated (cases) (CMS-2591, Line 72, Column 5)

FY 2005 Appeals Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
			o. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals **For Part B DAB referrals, requests for case files and effectuations:** a. Prepare draft Agency Referral memo and case file, and forward with the original ALJ case file to lead RO within 30 days of the date of the ALJ decision b. Receive and control the appellant's DAB review request or the DAB's request for a case file c. Retrieve case file d. Copy any additional correspondence and make a copy of the original case file and maintain e. Send original case file to the DAB f. Effectuate DAB's decision g. Enter case status information throughout the process of this activity and update as necessary	
12901	**PM CERT Support**	All PM costs associated with supporting the Comprehensive Error Rate Testing (CERT) contractor. **Reference:** • Program Integrity Manual (PIM) Chapter 12, Section 3.3.1 • PIM Chapter 12, Section 3.4 • PIM Chapter 12, Section 3.5 • PIM Chapter 12, Section 3.6.1 • PIM Chapter 12, Section 3.6.2	a. Provide sample information to the CERT Contractor as described in Pub 100-8 Ch. 12 § 3.3.1A&B b. Ensure that the correct provider address is supplied to the CERT Contractor as described in Pub 100-8 Ch 12 § 3.3.1.C c. Research 'no resolution' cases as described in Pub 100-8 Ch 12 § 3.3.1.B d. Handle and track CERT-initiated overpayments/underpayments as described in Pub 100-8 Ch 12. § 3.4 and 3.6.1 e. Handle and track appeals of CERT-initiated denials as described in Pub 100-8 Ch 12. § 3.5 and 3.6.2	

FY 2005 Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
13002	**Beneficiary Written Inquiries**	All costs associated with answering beneficiary/Congressional questions through correspondence. All costs associated with answering questions from beneficiaries visiting the Medicare Contractor facility. **Reference:** • Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.2	a. Log/Control and stamp all written inquiries with receipt date in mailroom b. Answer Inquiry in writing, via telephone, or e-mail c. Send Response d. Maintain Quality Control Program for written policies and procedures e. Transfer misrouted correspondence f. Establish a correspondence Quality Control Program g. Perform continuous quality reviews of outgoing letters h. Answer visitors' questions courteously and responsively (formerly walk-in inquiries)	**Workload 1** is the cumulative written inquiries as reported on the CMS-1566, Line 37, Beneficiary Column. **Workload 2** is the cumulative visitor inquiries (formerly walk-ins) as reported on the CMS-1566, Line 36, Beneficiary Column.
13004	**Customer Service Plans**	All costs associated providing beneficiary outreach and educational seminars, conferences and meetings for the contractor's entire geographic area and not limited to the local RO. **Reference:** • Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.5	a. Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups b. Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries c. Conduct Medicare awareness training/education with appropriate Congressional staffs to resolve beneficiary issues with Medicare	

FY 2005 Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
13005	**Beneficiary Telephone Inquiries**	All costs associated with answering beneficiary/Congressional questions over the telephone. All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response. All costs associated with planning/conducting training; and inputting/reviewing performance data. All costs associated with NGD deployment and operation. **Reference:** • Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 2, Section 20.1	a. Answer telephones b. Completing internal paperwork c. Inputting data into the system d. Analyzing reports and data e. Mailing information requested f. Making follow-up calls g. Monitoring Call h. Completing Scorecard i. Inputting Scorecard j. Reviewing Scorecard with CSR k. Planning/conducting training for CSRs l. Planning and deployment of NGD	**Workload 1** is the cumulative inquiries as reported on the CMS-1566, Line 35, Beneficiary Column.
13201	**Second Level Screening of Complaints Alleging Fraud and Abuse**	Costs associated with screening second level beneficiary inquiries of potential fraud and abuse that are closed, ordering medical records for beneficiary inquiries that are closed, and sending the referral package to the PSC or Medicare fee-for-service contractor BIU. This also includes the costs associated with the referral package for provider inquiries of potential fraud and abuse. Workload associated only with beneficiaries. **13201/01 – Second Level of Complaints Alleging Fraud and**	a. Calls the beneficiary (CR 2719 & PIM Chapter 4, §4.6-4.6.2) b. Reviews claims history (CR 2719 & PIM Chapter 4, §4.6-4.6.2) c. Reviews provider correspondence files for educational/warning letters or contact reports that relate to similar complaints (CR 2719 & PIM Chapter 4, §4.6-4.6.2) d. Requests itemized billing statements, when necessary (CR 2719 & PIM Chapter 4, §4.6-4.6.2) e. Requests medical records, when necessary (CR 2719 & PIM Chapter 4, §4.6-4.6.2) f. Resolves complaints, whenever possible (CR 2719 & PIM Chapter 4, §4.6-4.6.2) g. Refers complaints that are not fraud and abuse to the appropriate staff within the contractor or PSC, if appropriate (CR 2719 & PIM Chapter 4, §4.6-4.6.2)	**Workload 1** The total number of second level screening inquiries that were closed for beneficiaries. **Workload 2** The total number of medical records ordered for beneficiary inquiries that were closed. **Workload 3** The total number of potential beneficiary fraud and abuse complaints identified and referred to the PSC or Medicare fee-for-service

FY 2005 Beneficiary Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		Abuse by Providers – Costs associated with the referral package for provider inquiries of potential fraud and abuse. **Misc. Code:** 13201/01 – **Second Level of Complaints Alleging Fraud and Abuse by Providers** – Costs and workload associated with all provider inquiries of potential fraud and abuse.	h. Screens all Harkin Grantee complaints for fraud and abuse and maintains the Harkin Grantee Database (CR 2719 & PIM Chapter 4, §4.6-4.6.2, §4.12.3-4.12.4) i. Complies information in the Database into an aggregate report (PIM Chapter 4, §4.12.4) j. Distributes the aggregate report to the Harkin Grantee state project coordinator every 6 months and send copies of the report to CMS CO (PIM Chapter 4, §4.12.4) k. Screens all OIG Hotline complaints for fraud and abuse (CR 2719 & PIM Chapter 4, §4.6-4.6.2) l. Develops the referral package for the PSC or Medicare fee-for-service contractor BIU on fraud and abuse complaints (CR 2719 & PIM Chapter 4, §4.6-4.6.2) m. Refers the referral package to the PSC or Medicare fee-for-service contractor BIU within 30 calendar days of receipt of the complaint in the AC mailroom, or within 30 calendar days of receiving medical records (CR 2719 & PIM Chapter 4, §4.6-4.6.2) n. Maintains statistics and reports, as required (CR 2719 & PIM Chapter 4, §4.6-4.6.2)	contractor BIU.

FY 2005 Provider Communication (PCOM – PM) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
14101	**Provider/Supplier Information and Education Website**	All costs associated with maintaining an Internet web site that is dedicated to furnishing providers and suppliers with timely, accessible and understandable Medicare program information. This includes the costs associated with the development and maintenance of an internet web site. **Reference:** • IOM, Pub.100-09, Chapter 4, Section 20.1.7	a. Develop a website that is consistent with CMS requirements and website functionality. b. Periodically review the Web site standards Guidelines for compliance.	**Workload 1** is the number of page views at the URL (root) level for your provider education web site.
14102	**Electronic Mailing Lists/List-Servs**	All costs associated with the development and maintenance of electronic list-servs. **Reference:** • IOM, Pub.100-09, Chapter 4, Section 20.1.7	a. Provide registrants via e-mail of important and time sensitive Medicare program information. b. Notify registrants of the availability of contractor bulletins. c. Ensure that list-serv accommodates all providers/suppliers.	**Workload 1** is the total number of contractor provider/supplier PCOM electronic mailing lists. **Workload 2** is the total number of registrants on all the PCOM electronic mailing lists. **Workload 3** is the number of times contractors have used their list-serv(s) to communicate with providers/suppliers.

FY 2005 Reimbursement Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
16002	**Non-MSP Debt Collection/ Referral**	Recover overpayments **Reference:** • 42 CFR 405.370	a. Promptly suspend payments to providers to help assure the proper recovery of program overpayments and to help reduce the risk of uncollectable accounts b. Verify bankruptcy information for accuracy, timeliness, and coordinate with CMS/OGC to ensure proper treatment and collection of any overpayments to the Trust Funds c. Record overpayments determined by functional areas timely d. Refer all eligible delinquent debt to Treasury within 180 days of the debt becoming delinquent. (Do not include MSP debt referral on this line) e. Promptly review all extended repayment plan requests. Coordinate with regional and central office on Extended Repayment Plans (ERPs) that are over 12 months f. Process overpayments recoupments g. Documented attempts to collect overpayments timely. This includes attempting to locate providers and telephoning delinquent providers when necessary h. Assess systematic and manual interest on overpayments and underpayments correctly	
16003	**Interim Payment Control**	Establish, review, and revise interim payments rates **Reference:** • 42 CFR 413.64 (h) Provider Reimbursement • Manual 15 Part 1 Intermediary Manual/ Part I	a. Closely monitor provider compliance with interim payment requirements, especially those providers reimbursed under the periodic interim payment (PIP) method of reimbursement, and terminate providers from PIP, when necessary b. Review/revise Graduate Medical Education (GME), Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), bad debt, organ acquisition, interim rates, etc. c. Review documentation requests for special payment status such as sole community and Medicare dependent hospital	**Workload 1** is the number of provider interim rate reviews, including PIP reviews.
16004	**Reimbursement Report and File Maintenance**	Maintain data reports and files for provider reimbursement **Reference:** • 42 CFR Part 413 Program Memorandum 2197 under PM A-03-004 • Provider Reimbursement	a. Maintain accurate PPS Pricer Prov (provider specific) file b. Ensure an accurate System for Tracking Audit and Reimbursement (STAR) database is maintained, including ensuring that all information is properly entered and reported c. Maintain the Provider Statistical and Reimbursement (PS&R) system including testing all system updates and ensuring data is reliable for cost report settlements d. Obtain cost reports from providers including issuance of cost report	

FY 2005 Reimbursement Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		Manual 15 Part 1	submission reminder letters, PS&R reports, and demand letters e. Mass updates of cost to charge ratios	
16005	**Provider-Based Regulations**	Carry out all functions related to making provider-based determinations. **Reference:** • 42 CFR 413.65 • CR 2411	a. Process all provider applications or attestations and review all applications or attestations for completeness and accuracy b. Make any necessary on-site visits c. Carry out random sample reviews of providers that have not submitted any attestations or applications d. Take any necessary review or audit steps needed to allow CMS to make final provider-based determinations	**Workload 1** is the number of recommendations for approval made to the regional office (RO). **Workload 2** is the number of recommendations for disapproval made to the RO. **Workload 3** is the number of attestations received, but for which recommendations have not yet been made to the RO.

FY 2005 Provider/Supplier Enrollment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks*	Workload
31001	**Provider Enrollment**	Provider/supplier enrollment is a critical function to ensure only qualified healthcare organizations and entities are enrolled in the Medicare program. Healthcare organizations and entities must enroll with Fiscal Intermediaries (FIs), with whom they will do business, before receiving reimbursement for services furnished to Medicare beneficiaries. Each applicant will use the appropriate enrollment form and undergo the entire enrollment process, including verification of all of their information. **Reference:** • PIM Chapter 10*	a. Distribute all enrollment applications or refer applicants to the CMS web site (§2.2 and 23) b. Process initial applications (CMS 855A) from receipt to final recommendation to the State Agency and the Regional Office (RO), including verification of information and meeting CMS timeliness standards (§ 1, 2, 10 - 12, 14 - 21, 25) c. Process and verify Changes of Ownership (CHOWs) within CMS timeliness standards (§10) d. Process, verify and acknowledge changes of information via the CMS 855A within CMS timeliness standards. (§3,13) e. Process voluntary termination of billing numbers via the CMS-855A (§10.1) f. Verify and document provider enrollment information using the FID, Qualifier.Net, etc (§2.2) g. Image applications (i.e., for authorized and delegated official representative signatures) or maintain a hardcopy file to compare the signatures of the authorized representative and delegated official for changes to "pay-to" address (§2.2) h. Enter all application information into the Provider Enrollment, Chain, and Ownership System (PECOS) to include enrollment record information captured from in-house records when changes of information or tie-ins occur i. Monitor Community Mental Health Centers (CMHCs) and deactivate non-billing CMHCs (§11) j. Ensure staff is trained on enrollment requirements, procedures and techniques (§2) k. Respond to all phone calls and miscellaneous letters concerning enrollment in the Medicare program Provider enrollment-initiated educational projects should be charged to provider enrollment. Activities done in conjunction with the Provider Communications (PCOMM) group should be charged to the PCOMM line (§22) l. Provide a link to the CMS web site from your	**Workload 1** is the number of initial applications (CMS 855A) and buyer CHOWs received in a month. **Workload 2** is the number of changes of information (including seller CHOWs) received in a month. This includes cases where an enrollment record can be made and those where only logging and tracking could be performed. You will get credit for a change whether you create an enrollment record or not.

FY 2005 Provider/Supplier Enrollment Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks*	Workload
			contractor web site (§23) m. Initiate special projects as necessary or as requested by CMS n. Coordinate with other internal components (e.g., appeals, fraud unit, EFT processor, provider education/professional relations, ROs etc.). For EFTs, only charge provider enrollment for mailing the EFT form in the new provider packet and the verification of the bank account per CMS Pub 100-04, §30.2 (§2) o. Coordinate with other external components (e.g., OIG, Medicaid, FBI, Payment Safeguard Contractors (PSCs), State survey and certification agencies, etc.). When working with PSCs, the FI will charge their assistance to a PSC under one of the three designated workloads (see activity code 23201). Work not associated with one of these workloads is charged to provider enrollment (§2)	

FY 2005 Provider Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
33001	**Answering Provider Telephone Inquiries**	All costs associated with answering provider questions over the telephone. **Reference:** • IOM Pub 100-9 Chapter 3 §20.1.1-20.1.5 • IOM Pub 100-9 Chapter 3 §20.1.8-20.1.12	a. Answering the phones timely b. Completing internal paperwork c. Inputting data into the system d. Analyzing reports and data e. Sending requested information f. Making follow-up calls g. Implementing a provider satisfaction survey h. Developing a contingency plan i. Developing an IVR quality assurance plan j. All costs associated with purchasing and maintaining telephone systems and equipment	**Workload 1** is the cumulative inquiries as reported on the HCFA-1566, Line 35, Provider Column
33014	**Provider Quality Call Monitoring**	All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response. **Reference:** • IOM Pub 100-9 Chapter 3 §20.1.7	a. Monitoring Calls b. Completing Scorecard c. Inputting Scorecard d. Reviewing Scorecard with CSR	
33020	**Staff Development and Training**	All costs associated with the training and development of provider inquiries staff. **Reference:** • IOM Pub 100-9 Chapter 3 §20.1.6	a. Planning/conducting training for CSRs b. Attending CMS sponsored meetings, conferences, and train-the-trainer sessions related to provider customer service	

FY 2005 Provider Inquiries Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
33002	**Provider Written Inquiries**	All costs associated with answering provider questions through written correspondence. **Reference:** • IOM Pub 100-9 Chapter 3 §20.2	a. Logging/Controlling and date stamping all written inquiries in the mail room b. Responding to a written inquiry in writing, via telephone, or via e-mail c. Mailing the response (if applicable) d. Maintaining a Quality Control Program for written policies and procedures e. Transferring misrouted correspondence f. Maintaining a correspondence Quality Control Program g. Performing continuous quality reviews of outgoing letters	**Workload 1** is the number of provider written inquiries received by the contractor as reported on the CMS-1566, Line 37, Provider Column.
33003	**Provider Walk-In Inquiries**	All costs associated with answering questions from providers visiting the Medicare Contractor facility. **Reference:** • IOM Pub 100-9 Chapter 3 §20.3	a. Maintain sign–in sheets for walk-in individuals b. Keep records of contact by recording facts, questions, and responses given to individual c. Conduct inquiry interview d. Provide Medicare publications, as required	**Workload 1** is the cumulative inquiries as reported on the CMS-1566 Line 36, Provider Column.

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21001	**Automated Review**	When medical review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See IOM Pub. 100-8 Ch. 3 section 5.1 for further discussion of automated review. **Reference:** • IOM Pub. 100-8 Chapter 3, Section 3.4.5 (A) • IOM Pub. 100-8 Chapter 3, Section 3.5.1 • IOM Pub. 100-8 Chapter 11, Section 11.1.3.1	a. Develop edits b. Implement edits c. Generate denial letters if appropriate, this does not include collecting the over payment	**Workload 1** is the number of claims denied in whole or in part. **Workload 2** is the number of claims subjected to automated medical review, to the extent that contractors can report this.
21002	**Routine Reviews**	Routine review requires the intervention of specially trained non-clinical MR staff and is restricted to determination that can be made by review of the claim, attachments not requiring clinical judgment, and review of claims history. NOTE: Report post pay routine review workload denied due to lack of documentation on the remarks section of 21002. Do not include these denials in any other workload of this activity code. **Reference:** • IOM Pub. 100-8 Chapter 3, Section 3.4.5 (B) • IOM Pub. 100-8 Chapter 11, Section 11.1.3.2	a. Develop edits b. Implement edits c. Review claim d. Make determination e. Generate denial letter if appropriate, this does not include collecting the over payment	**Workload 1** is number of claims reviewed. **Workload 2** is number claims denied in whole or in part. **Workload 3** is the number of providers subjected to routine review.

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
21007	**Data Analysis**	Data Analysis is the integrated and on-going comparison of CERT findings, claim information, claims data deviations from standard practice, and other related data to identify potential provider service billing practices that may pose a threat to the Medicare Trust fund. This analysis can be a comparison of individual claim characteristics or in the aggregate of claims submissions. Analysis of data will lead to the generation of a list of program vulnerabilities that the contractor will use to focus their education and review resources. **Reference:** • IOM Pub. 100-8 Chapter 2, Section 2.2 • IOM Pub. 100-8 Chapter 11, Section 11.1.4	a. Collect data b. Analyze and compare data c. Identify potential program vulnerabilities d. Institute ongoing monitoring and modification of data analysis program components e. Develop and maintain trend reports over at least an 18-month period	
21010	**Third Party Liability (TPL) or Demand Bills**	Demand bills are bills submitted by the SNF or a RHHI at the beneficiary's request because the beneficiary disputes the provider's opinion that the bill will not be paid by Medicare and wishes the bill to be submitted for a payment determination. The demand bill is identified by the presence of a condition code 20. The SNF and RHHI must have a written request from the beneficiary to submit the bill, unless the beneficiary is deceased or incapable of signing. In this case, the beneficiary's guardian, relative, or other authorized representative may make the request. **Reference:** • IOM Pub. 100-8 Chapter 6, Section 6.1.1 • IOM Pub. 100-8 Chapter 11, Section	a. Review claim b. Request medical record and documentation c. Make determination d. Generate denial if appropriate, <u>this does not include collecting the over payment</u>	**Workload 1** report the number of claims (TPL and demand bills) reviewed. **Workload 2** report number of claims denied, in whole of in part. **Workload 3** report the number of demand bills. (IOM Pub. 100-8 Ch. 11)

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		11.1.6		
21206	**Policy Reconsideration/ Revision**	Contractors are to update Local Coverage Determinations (LCD). Costs accrued for transitioning Local Medical Review Policy (LMRP) to the LCD format should be captured here. **Reference:** • IOM Pub. 100-8 Chapter 11, Section 11.1.5.2 • IOM Pub. 100-8 Chapter 13, Section 13.4	a. Determine need (IOM Pub. 100-8, Ch. 3, § 4) b. Develop draft LCD change c. Solicit comments d. Compile and respond to comments e. Develop final policy f. Distribute policy g. Post LCD on to the database	**Workload 1** report the total number of policies/coverage determinations revised. **Workload 2** reports the total number of policies/coverage determinations that required notice and comment. **Workload 3** report total number of policies/coverage determinations revised due to outside request (e.g., beneficiary or provider request.)
21207	**MR Program Management**	MR Program Management encompasses managerial responsibilities inherent in managing the Medical Review (MR) and Local Provider Education & Training (LPET) Programs, including development, modification and periodic reports of MR/LPET Strategies and Quarterly	a. Review data from data analysis b. Develop and prioritize a problem list from the data analysis c. Determine the educational and review activities that will be used to address the problems on the problem list d. Develop and periodically modify Medical Review/LPET Strategy	

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		Analysis (QSA); quality assurance activities; planning, monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions. Any MR activity required for support of a PSC that performs MR activities should also be included in this code (this does not include MR to support the CERT contractor). **Reference:** • IOM Pub. 100-8 Chapter 11, Section 11.1.9	e. Track and modify problem list activities by using the QSA f. Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, Committee meetings, and periodic reports g. Evaluate edit effectiveness h. Plan, monitor, and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff i. Manage workload, including monitoring of monthly workload reports, re-allocation of staff resources, and shift in workload focus when indicated j. Implement Medical Review instruction from Regional and/or Central Office k. Educate staff on Medical Review issues, new instruction, and quality assurance findings l. MR PSC support activities	
21208	**New Policy Development Activities**	Contractors are to create Local Coverage Determinations (LCD) IOM 100-8 Chapter 13, Section 13.4. **Reference:** • IOM Pub. 100-8 Chapter 13, Section 13.4 • IOM Pub. 100-8 Chapter 11, Section 11.1.5.1	a. Determine need (See IOM Pub. 100-8, Ch. 13, § 4 (A) for circumstances requiring a need for LCD development) b. Develop draft LCD c. Solicit comments d. Compile and respond to comments e. Develop final LCD f. Distribute LCD g. Post LCD on to the database	**Workload 1** is the number of new LCDs that were presented for notice and comment**.** **Workload 2** is the number of LCDs that became effective.
21220	**Complex Probe Review**	Reports all costs associated with prepay and postpay Complex Probe Review. Prepay and postpay probe reviews are done to verify that the program vulnerability identified through data analysis actually exists and will require additional education and possible	a. Select sample b. Request medical records/additional information c. Review claim d. Make determination e. Generate denial/demand letters, if appropriate, this does not include	**Workload 1** is the number of claims reviewed. **Workload 2** is the number of claims denied in whole or in part.

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		review. **Reference:** • IOM Pub. 100-8, Chapter 3, Section 3.2 (A) • IOM Pub. 100-8, Chapter 11, Section 11.1.7.4	collecting the over payment	**Workload 3** is the number of providers subjected to complex probe review.
21221	**Prepay Complex Review**	Reports all costs associated with Prepay Complex Review. Prepay medical review of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made BEFORE claim payment. Complex medical review involves using clinical judgment by a licensed medical professional to evaluate medical records. Only claims reviewed based on a medical review edit and were addressed in the MR/LPET strategy shall be allocated to this activity line. **Reference:** • 100-8 Chapter 3, Section 3.4 • 100-8 Chapter 3, Section 3.4.5 • 100-8 Chapter 11, Section 11.1.3.3	a. Develop edits b. Implement edits c. Perform quality assurance of edits d. Request medical records and additional documents e. Review claim and documentation f. Make determination g. Generate denial letters, if appropriate, this does not include collecting the over payment	**Workload 1** is the number of claims reviewed. **Workload 2** is the number of claims denied in whole or in part. **Workload 3** is the number of providers subjected to complex review.
21222	**Postpay Complex Review**	All costs associated with Postpay Complex Review. Prepay medical review of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made AFTER claim payment. These types of review give the contractor the opportunity to make a determination to pay a claim (in full or in part), deny payment or assess an	a. Select claims b. Claim review c. Request medical records and additional documents d. Claim and Documentation review e. Make determination f. Generate overpayment demand letters, if appropriate, this does not include collecting the over payment	**Workload 1** is the total number of claims reviewed on a postpayment basis. **Workload 2** is the total number of claims denied in whole or in part. **Workload 3** is the number of providers subjected to

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		overpayment. Complex medical review involves using clinical judgment by a licensed medical professional to evaluate medical records. Only claims reviewed based on a medical review edit and were addressed in the MR/LPET strategy shall be allocated to this activity line. **Reference:** • IOM Pub. 100-8 Chapter 3, Section 3.4 • IOM Pub. 100-8 Chapter 3, Section 3.4.5 • IOM Pub. 100-8 Chapter 11, Section 11.1.7.2 • IOM Pub. 100-8 Chapter 11, Section 11.1.7.3 • IOM Pub. 100-8 Chapter 11, Section 11.1.7.4		postpayment review.
21901	**MIP Comprehensive Error Rate (CERT) Support**	Report the costs associated with time spent on activities to support the CERT contractor that are performed by the Medicare Integrity Program functional areas. **Reference:** • IOM Pub. 100-8 Chapter 12	a. Providing review information to the CERT Contractor as described in IOM Pub. 100-8 Ch. 12, § 3.3.2 b. Providing feedback information to the CERT Contractor as described in IOM Pub. 100-8 Ch. 12, § 3.3.3, including but not limited to: • CMD discussions about CERT findings • Participation in biweekly CERT conference calls • Responding to inquiries from the CERT contractor • Preparing dispute cases c. Preparing the Error Rate Reduction Plan (ERRP) as described in IOM Pub. 100-8 Ch. 12, § 3.9	

FY 2005 Medical Review Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
			d. Educating the provider community about CERT as described in IOM Pub. 100-8 Ch.12, § 3.8 e. Contacting non-responders and referring recalcitrant non-responders to the OIG as described in IOM Pub. 100-8 Ch. 12, § 3.15	

FY 2005 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
22001	**MSP Bills/Claims Prepayment**	All costs of activities associated to continued processing of a MSP claim after it enters the claims processing system, subsequent to initial claim entry, and activities necessary to aid in the processing of MSP Prepay-related Congressional hearings and appeals **Reference:** • Medicare Secondary Payer Manual, Chapters: 3, 5, 6 & 7	a. Resolve MSP claim edits occurring in the claim adjudication process within the standard systems and in response to CWF verification and validation b. Compare EOB/RA data attached to the MSP claim to HIMR/CWF data to identify the presence/absence of a CWF MSP Aux File record and to continue claim processing c. Contact the provider (for clarification- not development) if necessary, to avoid suspending the claim d. Add termination dates to MSP auxiliary records previously established on CWF with a "Y" validity indicator when no discrepancy exists in the validity of the CWF information and an active claim (simple terminations) e. Prepare a CWF Assistance Request to terminate a record only when a system problem exists or it fits existing CWF error codes/subject to the 6-month rule f. Work MSP suspended claims that have not processed through to final payment decision including: -Override a claim using conditional payment codes to process the claim a -Prepare an "I" record to accommodate an override -Determine to pay as primary or secondary or deny -*Follow up on COBC development/actions* -Address CWF Automatic Notices g. Complete MSP ECRS Inquiries and CWF Assistance Requests necessary to process the receipt of a claim through to payment or denial – Use C in the ECRS AC field. h. Follow up on prepay CWF Assistance Requests within designated timeframes i. Create "I" records when enough claim information exists to add a new CWF MSP Aux File record j. Process Congressional inquiries related to MSP Prepay functions and follow up with COBC within designated timeframes	**Workload 1** is the number of MSP claim edits resolved in the claim adjudication and CWF verification and validation processes and the "I" records prepared, necessary to complete the processing of a claim**.** **Workload 2** is the number of ECRS MSP Inquiries and CWF Assistance Requests transmitted to the COBC. **Workload 3** is the number of MSP prepays Congressional and hearing requests processed, including follow up with the COBC.

FY 2005 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
22005	**MSP Hospital Audits/On-site Reviews**	All costs of activities associated with the onsite review of hospitals, completion of reports and follow-up. **Reference:** • Medicare Secondary Payer Manual, Chapters: 3 & 5	a. Conduct on-site hospital reviews b. Prepare review reports to providers c. Conduct follow-up on corrective action plans with providers	**Workload 1** is the number of completed on-site reviews when a provider report has been submitted.
42002	**Liability, No-Fault, Workers' Compensation, Federal Tort Claim Act (FTCA)**	All costs of activities associated with the identification and establishment of a MSP Recovery claim specific to the named activity. **Reference:** • Medicare Secondary Payer Manual, Chapters: 2, 4, 5, 6, & 7	a. Research Medicare paid claims to identify claims related to a pending settlement, judgment, or award b. Identify Medicare's conditional payment amount c. Issue subsequent conditional payment amount notices (when appropriate) d. Respond to all case related inquiries (includes congressional inquiries) prior to the demand. e. Enter appropriate termination dates to CWF f. Calculate the Medicare recovery amount g. Issue recovery demand to appropriate individual or entity h. Coordinate with RO all pre-demand compromise requests i. Coordinate with CMS to effectuate FTCA recoveries j. Follow CMS directives for access to OSCAR, UPIN, & NSC data m. Perform appropriate case related ECRS transactions. Use R in the ECRS AC field	**Workload 1** is the number of recovery demand letters issued. **Workload 2** is the number of incoming correspondence. **Workload 3** is the number of resultant ECRS transactions.

FY 2005 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
42003	**Group Health Plan**	All costs of activities associated with identification and demand of all Medicare mistaken payments specific to the named activity. **Reference:** • Internet Only Manual Pub 100-5 Medicare Secondary Payer Manual, Chapters: 3 & 6	a. Install/run Data Match tapes b. Perform all Data Match and Non-Data Match history searches c. Develop & issue recovery demand letters (Data Match, Non-Data Match and DPP demands, as well as, demands resulting from 42 CFR 411.25 notices) taking into account existing search parameters and tolerances, if any d. Check CWF prior to mailing of recovery demands, if contractors' systems will not recognize an existing termination date on an MSP record, to ensure valid MSP periods e. Respond to any pre-demand Data Match & Non-Data Match incoming CORR related to a case f. Send copies of initial demand letters to the insurer/TPA of that employer (debtor) g. Perform all MPARTS status code updates related to actions up to and through the issuance of a recovery demand h. Perform appropriate case related ECRS transactions. Use G in the ECRS AC field	**Workload 1** is the number of GHP recovery demand letters issued to the debtor (do not count the copy). **Workload 2** is the number of MSP post payment case related ECRS transactions performed.
42004	**MSP General Inquires**	All costs of activities associated to MSP CORR that is <u>not case or active claim specific</u>. **Reference:** • Internet Only Manual Pub 100-5 Medicare Secondary Payer Manual, Chapters 3, 5, & 6	a. Perform appropriate general (non-case related and non-active claim related) ECRS transactions, including those that may be necessary for voluntary refunds/unsolicited refunds. Use I in the ECRS AC field. Take action on non-active claim and non-case related letters (including voluntary refunds/unsolicited refunds), faxes, e-mails, or telephone inquiries b. Respond to one time inquiries for outreach materials which may include the reproduction of these materials (those not counted in 42006) c. Enter non-case related and non-active claim related CWF termination dates d. Respond to OBRA 93 requests not related to an existing debt	**Workload 1** is the number of general MSP inquiries resolved. This includes OBRA 93 requests. **Workload 2** is the number of non-case related & non-active claim related ECRS transactions performed specific to voluntary/unsolicited refunds. **Workload 3** is the number of one-time inquiries requesting outreach materials.
42006	**Outreach**	All cost of activities associated to the development and presentation of MSP material to or for target audiences	a. Develop and /or revise/update audience appropriate outreach materials of recovery and presentation, e.g. beneficiary/insurer/provider handout materials (booklets and brochures) and internet Web sites b. Develop training materials and perform outreach presentations	**Workload 1** is the number of educational seminars, workshops, educational classes and/or face-to-face meetings.

FY 2005 Medicare Secondary Payer (MSP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
			c. Maintain and reproduce outreach materials as necessary d. Respond to written and phone request for outreach materials [Note: a onetime inquiry requesting outreach materials (which may/may not include reproduction of these materials should be reported under AC 42004- General Inquiries]	**Workload 2** is the number of videos or brochures created and /or revised. **Workload 3** is the number of changes/ updates or any new modules related to the WEB page and /or web based training modules.
42021	**Debt Collection/ Referral**	All costs of activities associated with the collection of all MSP debts and the referral of eligible delinquent MSP debt under the Debt Collection Act of 1996. **Reference:** • Internet Only Manual Pub 100-5 Medicare Secondary Payer Manual, Chapters: 3, 5, 6 & 7	a. Ensure proper recovery of MSP debts b. Respond and resolve all Corr or other inquiries regarding a debt within timelines parameters c. Adjudicate and post checks received timely d. Review and respond timely to "Extended Repayment Plan" (ERP) requests and monitor ongoing ERPs e. Resolve all post demand 1870 waiver requests f. Validate debts using CWF and address all pending CORR specific to the debt prior to issuing the "Intent to Refer" (ITR) letter g. Issue ITRs to the appropriate individual or entity (includes the copy of initial demand package) h. Resolve all Treasury Action form requests i. Perform appropriate recall actions and update all internal systems to reflect the progression of the debt resolution (e.g., MPARTS, DCS) j. Refer delinquent debts, as appropriate to Treasury k. Update all systems to reflect actions detailed on the Collections, Reconciliation/Acknowledgement form (CRAF) l. Perform appropriate debt related ECRS transactions (CWF assistance requests & ECRS inquiries). Use D in the ECRS AC field m. Take appropriate referral actions for all compromise or waiver of interest requests n. Develop/complete write-off – closed recommendation reports o. Ensure all MSP report detail are available and complete and can support reported figures (i.e., MSP savings)	**Workload 1** is the number of responses to initial demand letters received from the debtor /agent. **Workload 2** is the number of intent to refer to Treasury letters (ITRs) issued plus the number of responses received from ITRs (i.e., checks or CORR) **Workload 3** is the number of actual referrals to Treasury plus the number of Treasury action forms received.

FY 2005 Benefit Integrity Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definitions	Tasks	Workload
23201	PSC Support Services	The services that the AC will provide to support the BI activities being performed by the PSC (PIM) **Misc. Codes:** 23201/01 ACs record the total costs associated with miscellaneous PSC support services (e.g., training and meetings). 23201/02 ACs record the total costs associated with requests (not law enforcement requests) that they fulfill to support the PSC in investigations. 23201/03 ACs record the total costs associated with PSC requests for support from the AC with law enforcement requests.	a. Perform training for the PSC (PIM chapter 4 section 4.1) b. Conduct meetings in support of the PSC (PIM chapter 4, section 4.1) c. Prepare/supply additional documentation at the request of the PSC (PIM chapter 4, section 4.1) d. Install edits at the request of the PSC (PIM chapter 4, section 4.1)	**Workload 1** is the **n**umber of Miscellaneous PSC support services. **Workload 2** is the number of requests (not law enforcement) to support the PSC in investigations. **Workload 3** is the number of PSC requests for support from the AC with law enforcement requests.

FY 2005 Local Provider Education & Training (LPET)
Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
24116	**One-on-One Provider Education**.	Contractors must initiate provider one-on-one education in response to medical review related coverage, coding and billing problems identified, verified and prioritized through the analysis of information from various sources, including CERT findings and the medical review of claims. These educational contacts require clinical expertise and include face-to-face meetings, telephone conferences, or letters and electronic communications to a provider that address the provider's specific coding, coverage and billing issue. Included in this activity code are the costs and workload included in responding to provider questions concerning their specific medical review activities, or new or revised local policies. **Reference:** • IOM 100-8 Chapter 1, Section 5.1.1 • IOM 100-8 Chapter 11, Section 3.3.1	a. Analyze problem-specific data b. Determine appropriate educational method based on scope of problem c. Develop/produce educational information d. Deliver education	**Workload 1** is the number of educational contacts. **Workload 2** is the number of providers educated.
24117	**Education Delivered to a Group of Providers**	To remedy wide spread service-specific aberrancies, intermediaries may elect to educate a group of providers, rather than provide one-on-one contacts. Education delivered to a group of providers includes seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding Local Coverage Determinations (LCD), coverage, coding and billing considerations, and service or specialty specific issues. Clinical staff must be used as a resource. **Reference:** • IOM 100-8 Chapter 1, Section 5.1.2 • IOM 100-8 Chapter 11, Section 3.3.2	a. Analyze problem-specific data b. Determine appropriate educational method based on scope of problem c. Gather resources, including clinical staff expertise, and develop/produce educational information d. Select focus groups or site visits/meetings. If feasible, collaborate with partner groups in holding events e. Hold educational meeting with the presence of clinical staff	**Workload 1** is the number of educational contacts. **Workload 2** is the number of providers educated.
24118	**Education Delivered via**	Education delivered solely via paper media or electronically, without any live interactions is included	a. Analyze problem-specific data b. Develop and disseminate web-based searchable	**Workload 1** is the number of educational

FY 2005 Local Provider Education & Training (LPET)
Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
	Electronic or Paper Media	here. Contractors are required to maintain a website and adhere to instruction regarding them (IOM 100-8 Chapter 1, Sec. 5.A.9). Examples of this type of education include, but are not limited to, the development and dissemination of frequently asked questions (FAQs), scripted response documents, bulletin articles, LCD postings, comparative billing reports (CBRs) issued for other than one-on-one provider education. **Reference:** • IOM 100-8 Chapter 1, Section 5.1.3 • IOM 100-8 Chapter 11, Section 3.3.3	FAQs c. Develop and disseminate bulletin articles d. Develop and disseminate CBRs e. Develop and disseminate other types of electronic or paper media education	documents developed for use in non-interactive educational interventions. **Workload 2** is the number of CBRs developed (do not include CBRs developed for activities in 24116 and 24117). **Workload 3** is the number of articles/ advisories/bulletins developed.

FY 2005 Provider Communication (PCOM – MIP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
25103	**Create/Produce and Maintain Educational Bulletins**	All costs associated with the development, production and dissemination of provider bulletins/newsletters. **Reference:** • IOM, Pub.100-9, Chapter 4, Section 20.1.5	a. Gather resources and information to use in developing bulletin b. Develop bulletin c. Publish bulletin d. Disseminate bulletin	**Workload 1** is the total number of bulletin editions published. **Workload 2** is the total number of bulletins mailed.
25105	**Partner with External Entities**	All costs associated with the establishment and maintenance of collaborative provider education efforts with external entities. **Reference:** • IOM, Pub.100-09, Chapter 4, Section 20.1.12	a. Contact/communicate with external groups or organizations b. Work with external groups to foster and develop collaborative PET activities c. Obtain feedback on effectiveness and reach of partnering efforts	**Workload 1** is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee.
25201	**Administration and Management of PCOM Program**	All costs associated with administering and managing the provider communications program. Includes: research analysis and identification of provider education needs; planning of educational strategies, approaches, or efforts; training of staff in support education initiatives; and reporting of provider education activities and efforts. All costs associated with developing plans to outline the strategies, projected activities, efforts, and approaches that will be used in the forthcoming year to support physician/supplier education and training. **Reference:** • IOM, Pub.100-09, Chapter 4, Sections 20.1.1,2,3,10,11 & 20.2.1	a. Develop and submit PSP Report b. Develop and submit Quarterly Activity Reports c. Develop and maintain a provider inquiry analysis program d. Tally and analyze claim submission errors e. Solicit and analyze provider feedback f. Development and research responses to provider referrals of provider inquiries g. Hold periodic meetings with other contractor staff to ensure that issues raised by providers are being addressed through education h. Send at least one training representative to between 2-4 CMS-sponsored training events	**Workload 1** is the number of provider inquires referred to the provider communications area requiring technical experience, knowledge or research to answer.

FY 2005 Provider Communication (PCOM – MIP) Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
25202	**Develop Provider Education Material and Information**	All costs associated with the planning, design, research, writing and development of materials and information used to support provider education and training efforts. This includes work for new as well as substantially revised materials or information. **Misc. Code:** 25202/01 - **Special Media** - for costs associated with preparation of special media. **Reference:** • IOM, Pub.100-09, Chapter 4, Sections 20.1.14	a. Plan materials b. Research needed information c. Design, layout materials d. Write, illustrate or revise material e. Duplicate materials f. Prepare special media educational presentations (discretionary)	**Workload 1** is the number of special media efforts developed.
25203	**Disseminate Provider Information**	All costs associated with holding workshops seminars, classes and other provider education events or face-to-face meetings. (Does NOT include activities related to creation of bulletins or newsletters.) **Reference:** • IOM, Pub.100-09, Chapter 4, Sections 20.1.6,.8,.9,.13	a. Hold workshops, seminars, classes and other face to face meetings b. Disseminate Medicare provider information or materials at other provider education events or opportunities	**Workload** 1 is the number of educational seminars, workshops, classes and face-to-face meetings held. **Workload 2** is the number of attendees at your educational seminar workshops, classes and face-to-face training
25204	**Management and Operation of PCOM Advisory Group**	All costs associated with the management and operation of the PCOM Advisory Group (formerly the PET Advisory Group). **Reference:** • IOM, Pub.100-09, Chapter 4, Sections 20.1.4	a. Arrange PCOM Advisory Group meetings b. Solicit and maintain membership c. Obtain materials, supplies and equipment for meetings d. Produce and distribute PCOM Advisory Group information (agenda, minutes, etc.)	

FY 2005 Audit Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
26001	**Provider Desk Reviews**	Includes activities related to the cost report acceptance, tentative settlement, desk review and audit scoring. **Reference:** • CMS Medicare Manual system Pub 100-06 Financial Management • Chapter 8 Sections 10-20	a. Initial review to make sure the cost report is complete and acceptable b. Complete the Automated Desk Review (ADR) c. Cursory review and initial tentative settlement determination d. Professional desk review including the resolution of issues via phone or letter e. The determination of whether a field audit is to be performed and if so the scope f. Review of updated PS&R if cost report is not subjected to a field audit. g. Final review and approval of these procedures by a supervisor	**Workload 1** is Line 2a of the CASR IER, the total number of units (cost reports) when the desk reviews are completed. Line 2a is the total of lines 3a and 4a. **Workload 2** is Line 3a, the number of limited desk reviews. **Workload 3** is Line 4a, the number of full desk reviews.
26002	**Provider Audits**	Include all activities after the desk review but prior to the settlement. **Reference:** • CMS Medicare Manual System Pub 100-06 Financial Management • Chapter 8 Sections 30-80	a. Preliminary audit work including reviewing prior years workpapers b. Review of updated PS&R if cost report is subjected to a field audit c. All on-site audit work and proposed audit adjustments d. The entrance and exit conference f. The preparation of the final audit adjustment report g. Final review of the results by the supervisor	**Workload 1** is Line 6b of the CASR IER.
26003	**Provider Settlements**	Includes all work performed after the desk review/focus review and field audit through the NPR issuance. Do not include any appeal or hearing work. **Reference:** • CMS Medicare Manual System Pub 100-06 Financial Management • Chapter 8 Section 90	a. Reworking/review of the cost report after audit b. Preparation and typing of all transmittal letters (NPR and Management Letter) c. Final review by the supervisor for approval d. Issuing the NPR	**Workload 1** is Line 10a of the CASR IER, the number of cost reports settled.

FY 2005 Audit Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
26004	**Cost Report Re-openings**	Includes all work related to the reopening of a cost report. **Reference:** • CMS Medicare Manual System Pub 100-06 Financial Management • Chapter 8 Section 100	a. Review of the request for reopening b. Review documentation from the provider and determine if there is any change in the settlement c. If necessary, re-settle the re-opened cost report	**Workload 1** is Line 13b of the CASR IER, the number of re-openings completed.
26005	**Wage Index Review**	Includes all activities related to wage index reviews. **Reference:** • CMS Medicare Manual System Pub 100-06 Financial Management • Chapter 8 Section 20.4	a. Follow the most recent transmittal/Change Request containing detail procedures for wage index review tasks	**Workload 1** is a manual count of the number of hospital wage index reviews completed.
26010	**STAR Activities**	**NOTE:** This code is not included in the BPRs section for Audit because it is exclusively used by Mutual of Omaha to account for all work performed on the maintenance and enhancement of the STAR system **Reference:** • MIM 13.4 • STAR Procedures Manual	a. CMS will review and approve a yearly plan	

FY 2005 Audit Fiscal Intermediary Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
26011	**PRRB and Intermediary Hearings**	This code is now available to all FIs and includes all work performed on cost reports related to a provider's appeal. **Reference:** • MIM 13.4 • PRM 15 Part 1 • CR 1468	a. Prepare position papers b. Participate in meetings with providers including work performed relating to administrative resolutions c. Participate in any mediations with PRRB staff and with providers d. Prepare for board hearing and interact with BCBS attorneys e. Testify before PRRB f. Prepare any evidence for CMS attorney advisor if Administrator intervention to overturn board decision is necessary	**Workload 1** are cases closed – include all cases closed resulting from administrative resolutions, hearings, mediation, withdrawals, etc.